

Exhibit 28

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

PICA										PICA									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? PLACE (State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO L M T									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED SIGNATURE ON FILE DATE 02/25/11										a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY										b. EMPLOYER'S NAME OR SCHOOL NAME									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN										c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE									
19. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. L847.0 3. 4. 1										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
22. MEDICAID RESUBMISSION CODE										SIGNED SIGNATURE ON FILE									
23. PRIOR AUTHORIZATION NUMBER										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EXPECTED PAY PERIOD I. ID. QUAL J. RENDERING PROVIDER ID. #										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
1 12 10 10 12 10 10 11 97003 GO 12 225.00 1 MEGAN.RUTLEDGE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
2 12 10 10 12 10 10 11 97535 GO 12 70.00 1 MEGAN.RUTLEDGE										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
3 12 10 10 12 10 10 11 97110 GO 12 75.00 1 MEGAN.RUTLEDGE										23. PRIOR AUTHORIZATION NUMBER									
4 12 10 10 12 10 10 11 97140 GO 12 65.00 1 MEGAN.RUTLEDGE																			
5 12 10 10 12 10 10 11 97035 GO 12 60.00 1 MEGAN.RUTLEDGE																			
6 12 10 10 12 10 10 11 97014 GO 12 55.00 1 MEGAN.RUTLEDGE																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 27-1033080 <input type="checkbox"/> <input checked="" type="checkbox"/>										27. ACCEPT ASSIGNMENT? (For gov. cl. r's, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. PATIENT'S ACCOUNT NO. CHAJ0000 1286										28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 550.00 \$ \$ 550.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR SIGNED DATE 02/25/11										32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E.10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.									
33. BILLING PROVIDER INFO & PH. # ((586)) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021																			

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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO LMT c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
13. INSURED'S NAME OR SCHOOL NAME		14. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete Item 9 a-d.		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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21. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
23. RESERVED FOR LOCAL USE		24. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.0 2. 840.9 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 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611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443. 1444. 1445. 1446. 1447. 1448. 1449. 1450. 1451. 1452. 1453. 1454. 1455. 1456. 1457. 1458. 1459. 1460. 1461. 1462. 1463. 1464. 1465. 1466. 1467. 1468. 1469. 1470. 1471. 1472. 1473. 1474. 1475. 1476. 1477. 1478. 1479. 1480. 1481. 1482. 1483. 1484. 1485. 1486. 1487. 1488. 1489. 1490. 1491. 1492. 1493. 1494. 1495. 1496. 1497. 1498. 1499. 1500. 1501. 1502. 1503. 1504. 1505. 1506. 1507. 1508. 1509. 1510. 1511.			

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24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I.D. QUAL. J. RENDERING PROVIDER ID. #			
1 12 10 10 12 10 10 11 97001 GP 1 225.00 1 MANAS BASTHA			
2 12 10 10 12 10 10 11 97010 GP 1 55.00 1 MANAS BASTHA			
3 12 17 10 12 17 10 11 97010 GP 1 55.00 1 MANAS BASTHA			
4 12 17 10 12 17 10 11 97014 GP 1 55.00 1 MANAS BASTHA			
5 12 17 10 12 17 10 11 97035 GP 1 60.00 1 MANAS BASTHA			
6 12 17 10 12 17 10 11 97140 GP 1 65.00 1 MANAS BASTHA			
25. FEDERAL TAX I.D. NUMBER 27-1033080 26. PATIENT'S ACCOUNT NO. CHAJ0000 1285 27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 515.00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 515.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 02/25/11 MANAS BASTHA RPT SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	
		33. BILLING PROVIDER INFO & PH. # (586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021	

1500

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

PICA		PICA	
1. MEDICARE (Medicare #)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <u>MI</u> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		12. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 847.0 2. 840.9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HCP/CS MODIFIER F. \$ CHARGES G. DAYS OF UNITS H. EPST/PT/ST I. ID. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN 27-1033080		26. PATIENT'S ACCOUNT NO. CHAJ0000 1286	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 70.00	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 70.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR 02/25/11 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	
33. BILLING PROVIDER INFO & PH. # (586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.			

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [Blank]		3. PATIENT'S BIRTH DATE [Blank] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) [Blank]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [Blank]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [Blank]	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER [Blank]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [Blank]		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) LMI c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER [Blank]		a. INSURED'S DATE OF BIRTH [Blank] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME [Blank]	
c. EMPLOYER'S NAME OR SCHOOL NAME [Blank]		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
d. INSURANCE PLAN NAME OR PROGRAM NAME [Blank]		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 02/25/11		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT: MM DD YY 11 08 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		17a. [Blank] 17b. NPI 1760459994	
19. RESERVED FOR LOCAL USE		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24e by line) 1. 847.9 3. [Blank]		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST/PTM/FST I. ID. QUAL J. RENDERING PROVIDER ID. #		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES	
1 12 17 10 12 17 10 11 97110 GP 1 75.00 1 MANAS BASTHA		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2 01 21 11 01 21 11 11 97010 GP 1 55.00 1 JUSTES GEORGE		23. PRIOR AUTHORIZATION NUMBER	
3 01 21 11 01 21 11 11 97014 GP 1 55.00 1 JUSTES GEORGE			
4 01 21 11 01 21 11 11 97035 GP 1 60.00 1 JUSTES GEORGE			
5 01 21 11 01 21 11 11 97124 GP 1 60.00 1 JUSTES GEORGE			
6 01 21 11 01 21 11 11 97110 GP 1 75.00 1 JUSTES GEORGE			
25. FEDERAL TAX I.D. NUMBER 27-1033080 SSN EIN <input checked="" type="checkbox"/> <input type="checkbox"/>		28. PATIENT'S ACCOUNT NO. CHAJ0000 1285 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JUSTES GEORGE RPT. DATE 02/25/11		28. TOTAL CHARGE 380.00 29. AMOUNT PAID 30. BALANCE DUE 380.00	
32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b. [Blank]		33. BILLING PROVIDER INFO & PH. # (586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b. [Blank]	

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. OTHER INSURED'S DATE OF BIRTH		b. AUTO ACCIDENT?	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
a. INSURED'S DATE OF BIRTH		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
b. EMPLOYER'S NAME OR SCHOOL NAME		14. DATE OF CURRENT: MM DD YY	
c. INSURANCE PLAN NAME OR PROGRAM NAME		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE	
29. AMOUNT PAID		30. BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH. #		34. SIGNATURE OF PATIENT OR AUTHORIZED PERSON	

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE		5. PATIENT'S ADDRESS (No., Street)	
SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE 03/29/11		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT: 11 08 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line) 1. 847.0 2. 840.9 3. _____ 4. _____		22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS UNITS H. I.D. QUAL I. RENDERING PROVIDER ID. #			
1 01 21 11 01 21 11 11 97010 GO 12 55.00 1		MEGAN RUTLEDGE	
2 01 21 11 01 21 11 11 97014 GO 12 55.00 1		MEGAN RUTLEDGE	
3 01 21 11 01 21 11 11 97035 GO 12 60.00 1		MEGAN RUTLEDGE	
4 01 21 11 01 21 11 11 97140 GO 12 65.00 1		MEGAN RUTLEDGE	
5 01 21 11 01 21 11 11 97110 GO 12 75.00 1		MEGAN RUTLEDGE	
6 01 21 11 01 21 11 11 97535 GO 12 70.00 1		MEGAN RUTLEDGE	
25. FEDERAL TAX I.D. NUMBER 27-1033080 SSN EIN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. CHAJ0000 1412 27. ACCEPT ASSIGNMENT? (If gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 380.00 29. AMOUNT PAID \$ 380.00 30. BALANCE DUE \$ 380.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR SIGNED _____ DATE 03/29/11		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b. 1285954107	
33. BILLING PROVIDER INFO & PH. # (585) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021			

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE <input type="text"/> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		ZIP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F		a. INSURED'S DATE OF BIRTH <input type="text"/> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 03/29/11		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line) 1. 847.0 2. 840.9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSTY Payor ID. I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 01/28/11 01/28/11 11 97010 GO 12 55.00 1 NPI MEGAN RUTLEDGE		2 01/28/11 01/28/11 11 97014 GO 12 55.00 1 NPI MEGAN RUTLEDGE	
3 01/28/11 01/28/11 11 97035 GO 12 60.00 1 NPI MEGAN RUTLEDGE		4 01/28/11 01/28/11 11 97140 GO 12 65.00 1 NPI MEGAN RUTLEDGE	
5 01/28/11 01/28/11 11 97110 GO 12 75.00 1 NPI MEGAN RUTLEDGE		6 01/28/11 01/28/11 11 97535 GO 12 70.00 1 NPI MEGAN RUTLEDGE	
25. FEDERAL TAX I.D. NUMBER 27-1033080 SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. CHAJ0000 1412	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 380.00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 380.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR SIGNED DATE 03/29/11		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	
33. BILLING PROVIDER INFO & PH. # (585) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021			

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (X-10)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
3. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street)												7. INSURED'S ADDRESS (No., Street)			
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>												11. INSURED'S POLICY GROUP OR FECA NUMBER			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>												c. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.			
d. INSURANCE PLAN NAME OR PROGRAM NAME												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															
SIGNATURE ON FILE DATE 03/29/11															

14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY															
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 1760459994															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN															
18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE															
20. OUTSIDE LAB? \$ CHARGES															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.0 2. 840.9															

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS UNITS		H. I.D. QUAL.		J. RENDERING PROVIDER ID. #	
02	09	11	02	09	11	11	97010	GO	12	55.00	1					MEGAN RUTLEDGE	
02	09	11	02	09	11	11	97014	GO	12	55.00	1					MEGAN RUTLEDGE	
02	09	11	02	09	11	11	97035	GO	12	60.00	1					MEGAN RUTLEDGE	
02	09	11	02	09	11	11	97140	GO	12	65.00	1					MEGAN RUTLEDGE	
02	09	11	02	09	11	11	97110	GO	12	75.00	1					MEGAN RUTLEDGE	
02	09	11	02	09	11	11	97535	GO	12	70.00	1					MEGAN RUTLEDGE	

25. FEDERAL TAX I.D. NUMBER 27-1033080		26. PATIENT'S ACCOUNT NO. CHAJ0000 1412		27. ACCEPT ASSIGNMENT? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 380.00		29. AMOUNT PAID		30. BALANCE DUE \$ 380.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR SIGNED DATE 03/29/11				32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.				33. BILLING PROVIDER INFO & PH. # (586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.			

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
13. INSURED'S NAME OR SCHOOL NAME		14. EMPLOYER'S NAME OR SCHOOL NAME	
15. INSURANCE PLAN NAME OR PROGRAM NAME		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNATURE ON FILE		SIGNATURE ON FILE	
19. DATE OF CURRENT: 11/08/10		20. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
23. RESERVED FOR LOCAL USE		24. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 847.9		26. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
27. PRIOR AUTHORIZATION NUMBER		28. DATE(S) OF SERVICE	
29. DATE(S) OF SERVICE		30. DATE(S) OF SERVICE	
31. DATE(S) OF SERVICE		32. DATE(S) OF SERVICE	
33. DATE(S) OF SERVICE		34. DATE(S) OF SERVICE	
35. DATE(S) OF SERVICE		36. DATE(S) OF SERVICE	
37. DATE(S) OF SERVICE		38. DATE(S) OF SERVICE	
39. DATE(S) OF SERVICE		40. DATE(S) OF SERVICE	
41. DATE(S) OF SERVICE		42. DATE(S) OF SERVICE	
43. DATE(S) OF SERVICE		44. DATE(S) OF SERVICE	
45. DATE(S) OF SERVICE		46. DATE(S) OF SERVICE	
47. DATE(S) OF SERVICE		48. DATE(S) OF SERVICE	
49. DATE(S) OF SERVICE		50. DATE(S) OF SERVICE	
51. DATE(S) OF SERVICE		52. DATE(S) OF SERVICE	
53. DATE(S) OF SERVICE		54. DATE(S) OF SERVICE	
55. DATE(S) OF SERVICE		56. DATE(S) OF SERVICE	
57. DATE(S) OF SERVICE		58. DATE(S) OF SERVICE	
59. DATE(S) OF SERVICE		60. DATE(S) OF SERVICE	
61. DATE(S) OF SERVICE		62. DATE(S) OF SERVICE	
63. DATE(S) OF SERVICE		64. DATE(S) OF SERVICE	
65. DATE(S) OF SERVICE		66. DATE(S) OF SERVICE	
67. DATE(S) OF SERVICE		68. DATE(S) OF SERVICE	
69. DATE(S) OF SERVICE		70. DATE(S) OF SERVICE	
71. DATE(S) OF SERVICE		72. DATE(S) OF SERVICE	
73. DATE(S) OF SERVICE		74. DATE(S) OF SERVICE	
75. DATE(S) OF SERVICE		76. DATE(S) OF SERVICE	
77. DATE(S) OF SERVICE		78. DATE(S) OF SERVICE	
79. DATE(S) OF SERVICE		80. DATE(S) OF SERVICE	
81. DATE(S) OF SERVICE		82. DATE(S) OF SERVICE	
83. DATE(S) OF SERVICE		84. DATE(S) OF SERVICE	
85. DATE(S) OF SERVICE		86. DATE(S) OF SERVICE	
87. DATE(S) OF SERVICE		88. DATE(S) OF SERVICE	
89. DATE(S) OF SERVICE		90. DATE(S) OF SERVICE	
91. DATE(S) OF SERVICE		92. DATE(S) OF SERVICE	
93. DATE(S) OF SERVICE		94. DATE(S) OF SERVICE	
95. DATE(S) OF SERVICE		96. DATE(S) OF SERVICE	
97. DATE(S) OF SERVICE		98. DATE(S) OF SERVICE	
99. DATE(S) OF SERVICE		100. DATE(S) OF SERVICE	

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 		3. PATIENT'S BIRTH DATE <input type="text"/> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) 		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER 	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 03/29/11		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.0 3. 840.9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST POLY REF I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 02 17 11 02 17 11 11 97010 GO 12 55.00 1 MEGAN RUTLEDGE		2 02 17 11 02 17 11 11 97014 GO 12 55.00 1 MEGAN RUTLEDGE	
3 02 17 11 02 17 11 11 97035 GO 12 60.00 1 MEGAN RUTLEDGE		4 02 17 11 02 17 11 11 97140 GO 12 65.00 1 MEGAN RUTLEDGE	
5 02 17 11 02 17 11 11 97110 GO 12 75.00 1 MEGAN RUTLEDGE		6 02 17 11 02 17 11 11 97535 GO 12 70.00 1 MEGAN RUTLEDGE	
25. FEDERAL TAX I.D. NUMBER 27-1033080 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. CHAJ0000 1412	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 380.00 29. AMOUNT PAID \$ 380.00 30. BALANCE DUE \$ 380.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR SIGNED DATE 03/29/11		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	
33. BILLING PROVIDER INFO & PH. # (586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021			

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (X/ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) CITY ZIP	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED DATE 03/29/11		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED	
14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 847.9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPSDT I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 02 17 11 02 17 11 11 97014 GP 1 55.00 1 JUSTES GEORGE		2 02 17 11 02 17 11 11 97035 GP 1 60.00 1 JUSTES GEORGE	
3 02 17 11 02 17 11 11 97140 GP 1 65.00 1 JUSTES GEORGE		4 02 24 11 02 24 11 11 97010 GP 1 55.00 1 JUSTES GEORGE	
5 02 24 11 02 24 11 11 97014 GP 1 55.00 1 JUSTES GEORGE		6 02 24 11 02 24 11 11 97035 GP 1 60.00 1 JUSTES GEORGE	
25. FEDERAL TAX I.D. NUMBER SSN EIN 27-1033080 <input checked="" type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (By gov. clm. see back) CHAJ0000 1413 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) JUSTES GEORGE RPT SIGNED DATE 03/29/11		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	
33. BILLING PROVIDER INFO & PH. # ((586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021		28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 350.00 \$ 350.00	

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 03/29/11		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 847.0 2. 840.9 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 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STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		14. INSURED'S DATE OF BIRTH <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
15. EMPLOYER'S NAME OR SCHOOL NAME		16. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
17. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
19. SIGNATURE ON FILE SIGNED _____ DATE 03/29/11		20. SIGNATURE ON FILE SIGNED _____	
21. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		22. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		24. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
25. RESERVED FOR LOCAL USE		26. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line) 847.9		28. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
29. MEDICAID RESUBMISSION CODE		30. ORIGINAL REF NO	
31. PRIOR AUTHORIZATION NUMBER		32. DATE(S) OF SERVICE	
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539. DATE(S) OF SERVICE		5	

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		ZIP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
c. EMPLOYER'S NAME OR SCHOOL NAME		a. INSURED'S DATE OF BIRTH SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
SIGNATURE ON FILE DATE 03/29/11		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
14. DATE OF CURRENT: 11 08 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		SIGNED SIGNATURE ON FILE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN	
17a. NPI 1760459994		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line) 1. 847.0 2. 840.9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS UNTIL H. 9/801 I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 02 25 11 02 25 11 11 97010 GO 12 55.00 1 NPI MEGAN RUTLEDGE		2 02 25 11 02 25 11 11 97014 GO 12 55.00 1 NPI MEGAN RUTLEDGE	
3 02 25 11 02 25 11 11 97035 GO 12 60.00 1 NPI MEGAN RUTLEDGE		4 02 25 11 02 25 11 11 97140 GO 12 65.00 1 NPI MEGAN RUTLEDGE	
5 02 25 11 02 25 11 11 97110 GO 12 75.00 1 NPI MEGAN RUTLEDGE		6 02 25 11 02 25 11 11 97535 GO 12 70.00 1 NPI MEGAN RUTLEDGE	
25. FEDERAL TAX I.D. NUMBER SSN EIN 27-1033080 <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 380.00 \$ 380.00		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MEGAN RUTLEDGE OTR SIGNED DATE 03/29/11	
32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.		33. BILLING PROVIDER INFO & PH. # (585) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.	

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [Blank]		3. PATIENT'S BIRTH DATE [Blank] M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) [Blank]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [Blank]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [Blank]	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [Blank]		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER [Blank]		11. INSURED'S POLICY GROUP OR FECA NUMBER [Blank]	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH [Blank] M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME [Blank]		b. EMPLOYER'S NAME OR SCHOOL NAME [Blank]	
d. INSURANCE PLAN NAME OR PROGRAM NAME [Blank]		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED [Blank] DATE 03/29/11		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
14. DATE OF CURRENT: 11/08/10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED [Blank]	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line) 1. 847.9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS UNITS H. PARTIAL PAY I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 02 25 11 02 25 11 11 97110 GP 1 75.00 1 JUSTES GEORGE			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER 27-1033080 SSN EIN <input checked="" type="checkbox"/> X		28. PATIENT'S ACCOUNT NO. CHAJ0000 1413 27. ACCEPT ASSIGNMENT? (If gov't claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JUSTES GEORGE RPT SIGNED DATE 03/29/11		32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E. 10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	
33. BILLING PROVIDER INFO & PH. # (586) 774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021		29. TOTAL CHARGE 75.00 29. AMOUNT PAID 75.00 30. BALANCE DUE 75.00	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (NO)										1a. INSURED'S I.D. NUMBER (For Program in item 1) 22C457642																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) _____										3. PATIENT'S BIRTH DATE _____										4. INSURED'S NAME (Last Name, First Name, Middle Initial) _____									
5. PATIENT'S ADDRESS (No., Street) _____										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) _____									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) _____										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 12. INSURED'S POLICY OR GROUP NUMBER _____									
13. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> 14. EMPLOYER'S NAME OR SCHOOL NAME _____										15. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 16. EMPLOYER'S NAME OR SCHOOL NAME _____										17. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 18. EMPLOYER'S NAME OR SCHOOL NAME _____									
19. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE										20. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.										21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. _____									
22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE 11/04/11										23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____										24. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____									
25. DATE OF CURRENT: MM DD YY 05 09 11 26. ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY TERRY REZNICK D.O.										27. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 17a. _____ 17b. NPI 1295874451										28. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
30. RESERVED FOR LOCAL USE										31. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 32. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										33. PRIOR AUTHORIZATION NUMBER									
34. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1, 2, 3 or 4 to item 24E by line) 1. 847.9										35. DATE(S) OF SERVICE From MM DD YY To MM DD YY 36. PLACE OF SERVICE 37. CPT/PCS 38. MODIFIER 39. DIAGNOSIS POINTER 40. \$ CHARGES 41. DAYS OR UNITS 42. FEE 43. ID. QUAL. 44. RENDERING PROVIDER ID. #										45. DATE(S) OF SERVICE From MM DD YY To MM DD YY 46. PLACE OF SERVICE 47. CPT/PCS 48. MODIFIER 49. DIAGNOSIS POINTER 50. \$ CHARGES 51. DAYS OR UNITS 52. FEE 53. ID. QUAL. 54. RENDERING PROVIDER ID. #									
55. FEDERAL TAX ID NUMBER 80-0503391 56. PATIENT'S ACCOUNT NO. SCOPA000 1358 57. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										58. TOTAL CHARGE \$ 375.00 59. AMOUNT PAID \$ 60. BALANCE DUE \$ 375.00										61. BILLING PROVIDER INFO & PH. # (810) 230-0444 62. NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532									
63. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SONI SIGNED _____ DATE 09/19/11										64. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.										65. BILLING PROVIDER INFO & PH. # (810) 230-0444 66. NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.									

FIRST FOLD HERE WHEN MAILING

SECOND FOLD HERE

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

KMRPPT0066571

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		10. INSURED'S I.D. NUMBER (For Program in Item 1) 22C457642	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 12/29/11		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 05 09 11		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE TERRY REZNICK D.O.		17a. NPI 1295874451	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 8470 2. 847.1		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I.D. QUAL I. RENDERING PROVIDER ID #			
108 10 11 08 10 11 11 97110 GO 12 75.00 1		RUTLEDGE NPI	
208 10 11 08 10 11 11 97535 GO 12 65.00 1		RUTLEDGE NPI	
308 15 11 08 15 11 11 97010 GO 12 60.00 1		RUTLEDGE NPI	
408 15 11 08 15 11 11 97014 GO 12 55.00 1		RUTLEDGE NPI	
508 15 11 08 15 11 11 97124 GO 12 60.00 1		RUTLEDGE NPI	
608 15 11 08 15 11 11 97110 GO 12 75.00 1		RUTLEDGE NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 80-0503391 <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. SCOPA000 1430	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 390.00	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 390.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 11/11/10 RUTLEDGE SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139	
		33. BILLING PROVIDER INFO & PH. # NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 b. 1336469139	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0066511

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (10)		12. INSURED'S I.D. NUMBER (For Program in Item 1) 22C457642	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) MI c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		14. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
15. EMPLOYER'S NAME OR SCHOOL NAME		16. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
17. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
19. SIGNATURE ON FILE DATE 11/04/11		20. SIGNATURE ON FILE	
21. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 05 09 11		22. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE TERRY REZNICK D.O.		24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
25. RESERVED FOR LOCAL USE		26. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES	
27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 847.9		28. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
29. PRIOR AUTHORIZATION NUMBER		30. DATE(S) OF SERVICE From MM DD YY To MM DD YY	
31. PLACE OF SERVICE EMO		32. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
33. DIAGNOSIS POINTER		34. \$ CHARGES	
35. DAYS OR UNITS		36. ID. QUAL	
37. RENDERING PROVIDER ID. #		38. \$ CHARGES	
39. DATE(S) OF SERVICE From MM DD YY To MM DD YY		40. \$ CHARGES	
41. PLACE OF SERVICE EMO		42. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
43. DIAGNOSIS POINTER		44. \$ CHARGES	
45. DAYS OR UNITS		46. ID. QUAL	
47. RENDERING PROVIDER ID. #		48. \$ CHARGES	
49. DATE(S) OF SERVICE From MM DD YY To MM DD YY		50. \$ CHARGES	
51. PLACE OF SERVICE EMO		52. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
53. DIAGNOSIS POINTER		54. \$ CHARGES	
55. DAYS OR UNITS		56. ID. QUAL	
57. RENDERING PROVIDER ID. #		58. \$ CHARGES	
59. DATE(S) OF SERVICE From MM DD YY To MM DD YY		60. \$ CHARGES	
61. PLACE OF SERVICE EMO		62. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
63. DIAGNOSIS POINTER		64. \$ CHARGES	
65. DAYS OR UNITS		66. ID. QUAL	
67. RENDERING PROVIDER ID. #		68. \$ CHARGES	
69. DATE(S) OF SERVICE From MM DD YY To MM DD YY		70. \$ CHARGES	
71. PLACE OF SERVICE EMO		72. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
73. DIAGNOSIS POINTER		74. \$ CHARGES	
75. DAYS OR UNITS		76. ID. QUAL	
77. RENDERING PROVIDER ID. #		78. \$ CHARGES	
79. DATE(S) OF SERVICE From MM DD YY To MM DD YY		80. \$ CHARGES	
81. PLACE OF SERVICE EMO		82. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
83. DIAGNOSIS POINTER		84. \$ CHARGES	
85. DAYS OR UNITS		86. ID. QUAL	
87. RENDERING PROVIDER ID. #		88. \$ CHARGES	
89. DATE(S) OF SERVICE From MM DD YY To MM DD YY		90. \$ CHARGES	
91. PLACE OF SERVICE EMO		92. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
93. DIAGNOSIS POINTER		94. \$ CHARGES	
95. DAYS OR UNITS		96. ID. QUAL	
97. RENDERING PROVIDER ID. #		98. \$ CHARGES	
99. DATE(S) OF SERVICE From MM DD YY To MM DD YY		100. \$ CHARGES	
101. PLACE OF SERVICE EMO		102. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
103. DIAGNOSIS POINTER		104. \$ CHARGES	
105. DAYS OR UNITS		106. ID. QUAL	
107. RENDERING PROVIDER ID. #		108. \$ CHARGES	
109. DATE(S) OF SERVICE From MM DD YY To MM DD YY		110. \$ CHARGES	
111. PLACE OF SERVICE EMO		112. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
113. DIAGNOSIS POINTER		114. \$ CHARGES	
115. DAYS OR UNITS		116. ID. QUAL	
117. RENDERING PROVIDER ID. #		118. \$ CHARGES	
119. DATE(S) OF SERVICE From MM DD YY To MM DD YY		120. \$ CHARGES	
121. PLACE OF SERVICE EMO		122. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
123. DIAGNOSIS POINTER		124. \$ CHARGES	
125. DAYS OR UNITS		126. ID. QUAL	
127. RENDERING PROVIDER ID. #		128. \$ CHARGES	
129. DATE(S) OF SERVICE From MM DD YY To MM DD YY		130. \$ CHARGES	
131. PLACE OF SERVICE EMO		132. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
133. DIAGNOSIS POINTER		134. \$ CHARGES	
135. DAYS OR UNITS		136. ID. QUAL	
137. RENDERING PROVIDER ID. #		138. \$ CHARGES	
139. DATE(S) OF SERVICE From MM DD YY To MM DD YY		140. \$ CHARGES	
141. PLACE OF SERVICE EMO		142. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
143. DIAGNOSIS POINTER		144. \$ CHARGES	
145. DAYS OR UNITS		146. ID. QUAL	
147. RENDERING PROVIDER ID. #		148. \$ CHARGES	
149. DATE(S) OF SERVICE From MM DD YY To MM DD YY		150. \$ CHARGES	
151. PLACE OF SERVICE EMO		152. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
153. DIAGNOSIS POINTER		154. \$ CHARGES	
155. DAYS OR UNITS		156. ID. QUAL	
157. RENDERING PROVIDER ID. #		158. \$ CHARGES	
159. DATE(S) OF SERVICE From MM DD YY To MM DD YY		160. \$ CHARGES	
161. PLACE OF SERVICE EMO		162. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
163. DIAGNOSIS POINTER		164. \$ CHARGES	
165. DAYS OR UNITS		166. ID. QUAL	
167. RENDERING PROVIDER ID. #		168. \$ CHARGES	
169. DATE(S) OF SERVICE From MM DD YY To MM DD YY		170. \$ CHARGES	
171. PLACE OF SERVICE EMO		172. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
173. DIAGNOSIS POINTER		174. \$ CHARGES	
175. DAYS OR UNITS		176. ID. QUAL	
177. RENDERING PROVIDER ID. #		178. \$ CHARGES	
179. DATE(S) OF SERVICE From MM DD YY To MM DD YY		180. \$ CHARGES	
181. PLACE OF SERVICE EMO		182. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
183. DIAGNOSIS POINTER		184. \$ CHARGES	
185. DAYS OR UNITS		186. ID. QUAL	
187. RENDERING PROVIDER ID. #		188. \$ CHARGES	
189. DATE(S) OF SERVICE From MM DD YY To MM DD YY		190. \$ CHARGES	
191. PLACE OF SERVICE EMO		192. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
193. DIAGNOSIS POINTER		194. \$ CHARGES	
195. DAYS OR UNITS		196. ID. QUAL	
197. RENDERING PROVIDER ID. #		198. \$ CHARGES	
199. DATE(S) OF SERVICE From MM DD YY To MM DD YY		200. \$ CHARGES	
201. PLACE OF SERVICE EMO		202. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
203. DIAGNOSIS POINTER		204. \$ CHARGES	
205. DAYS OR UNITS		206. ID. QUAL	
207. RENDERING PROVIDER ID. #		208. \$ CHARGES	
209. DATE(S) OF SERVICE From MM DD YY To MM DD YY		210. \$ CHARGES	
211. PLACE OF SERVICE EMO		212. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
213. DIAGNOSIS POINTER		214. \$ CHARGES	
215. DAYS OR UNITS		216. ID. QUAL	
217. RENDERING PROVIDER ID. #		218. \$ CHARGES	
219. DATE(S) OF SERVICE From MM DD YY To MM DD YY		220. \$ CHARGES	
221. PLACE OF SERVICE EMO		222. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
223. DIAGNOSIS POINTER		224. \$ CHARGES	
225. DAYS OR UNITS		226. ID. QUAL	
227. RENDERING PROVIDER ID. #		228. \$ CHARGES	
229. DATE(S) OF SERVICE From MM DD YY To MM DD YY		230. \$ CHARGES	
231. PLACE OF SERVICE EMO		232. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
233. DIAGNOSIS POINTER		234. \$ CHARGES	
235. DAYS OR UNITS		236. ID. QUAL	
237. RENDERING PROVIDER ID. #		238. \$ CHARGES	
239. DATE(S) OF SERVICE From MM DD YY To MM DD YY		240. \$ CHARGES	
241. PLACE OF SERVICE EMO		242. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
243. DIAGNOSIS POINTER		244. \$ CHARGES	
245. DAYS OR UNITS		246. ID. QUAL	
247. RENDERING PROVIDER ID. #		248. \$ CHARGES	
249. DATE(S) OF SERVICE From MM DD YY To MM DD YY		250. \$ CHARGES	
251. PLACE OF SERVICE EMO		252. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
253. DIAGNOSIS POINTER		254. \$ CHARGES	
255. DAYS OR UNITS		256. ID. QUAL	
257. RENDERING PROVIDER ID. #		258. \$ CHARGES	
259. DATE(S) OF SERVICE From MM DD YY To MM DD YY		260. \$ CHARGES	
261. PLACE OF SERVICE EMO		262. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
263. DIAGNOSIS POINTER		264. \$ CHARGES	
265. DAYS OR UNITS		266. ID. QUAL	
267. RENDERING PROVIDER ID. #		268. \$ CHARGES	
269. DATE(S) OF SERVICE From MM DD YY To MM DD YY		270. \$ CHARGES	
271. PLACE OF SERVICE EMO		272. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
273. DIAGNOSIS POINTER		274. \$ CHARGES	
275. DAYS OR UNITS		276. ID. QUAL	
277. RENDERING PROVIDER ID. #		278. \$ CHARGES	
279. DATE(S) OF SERVICE From MM DD YY To MM DD YY		280. \$ CHARGES	
281. PLACE OF SERVICE EMO		282. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
283. DIAGNOSIS POINTER		284. \$ CHARGES	
285. DAYS OR UNITS		286. ID. QUAL	
287. RENDERING PROVIDER ID. #		288. \$ CHARGES	
289. DATE(S) OF SERVICE From MM DD YY To MM DD YY		290. \$ CHARGES	
291. PLACE OF SERVICE EMO		292. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
293. DIAGNOSIS POINTER		294. \$ CHARGES	
295. DAYS OR UNITS		296. ID. QUAL	
297. RENDERING PROVIDER ID. #		298. \$ CHARGES	
299. DATE(S) OF SERVICE From MM DD YY To MM DD YY		300. \$ CHARGES	
301. PLACE OF SERVICE EMO		302. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
303. DIAGNOSIS POINTER		304. \$ CHARGES	
305. DAYS OR UNITS		306. ID. QUAL	
307. RENDERING PROVIDER ID. #		308. \$ CHARGES	
309. DATE(S) OF SERVICE From MM DD YY To MM DD YY		310. \$ CHARGES	
311. PLACE OF SERVICE EMO		312. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
313. DIAGNOSIS POINTER		314. \$ CHARGES	
315. DAYS OR UNITS		316. ID. QUAL	
317. RENDERING PROVIDER ID. #		318. \$ CHARGES	
319. DATE(S) OF SERVICE From MM DD YY To MM DD YY		320. \$ CHARGES	
321. PLACE OF SERVICE EMO		322. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
323. DIAGNOSIS POINTER		324. \$ CHARGES	
325. DAYS OR UNITS		326. ID. QUAL	
327. RENDERING PROVIDER ID. #		328. \$ CHARGES	
329. DATE(S) OF SERVICE From MM DD YY To MM DD YY		330. \$ CHARGES	
331. PLACE OF SERVICE EMO		332. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
333. DIAGNOSIS POINTER		334. \$ CHARGES	
335. DAYS OR UNITS		336. ID. QUAL	
337. RENDERING PROVIDER ID. #		338. \$ CHARGES	
339. DATE(S) OF SERVICE From MM DD YY To MM DD YY		340. \$ CHARGES	
341. PLACE OF SERVICE EMO		342. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
343. DIAGNOSIS POINTER		344. \$ CHARGES	
345. DAYS OR UNITS		346. ID. QUAL	
347. RENDERING PROVIDER ID. #		348. \$ CHARGES	
349. DATE(S) OF SERVICE From MM DD YY To MM DD YY		350. \$ CHARGES	
351. PLACE OF SERVICE EMO		352. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
353. DIAGNOSIS POINTER		354. \$ CHARGES	
355. DAYS OR UNITS		356. ID. QUAL	
357. RENDERING PROVIDER ID. #		358. \$ CHARGES	
359. DATE(S) OF SERVICE From MM DD YY To MM DD YY		360. \$ CHARGES	
361. PLACE OF SERVICE EMO		362. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
363. DIAGNOSIS POINTER		364. \$ CHARGES	
365. DAYS OR UNITS		366. ID. QUAL	
367. RENDERING PROVIDER ID. #		368. \$ CHARGES	
369. DATE(S) OF SERVICE From MM DD YY To MM DD YY		370. \$ CHARGES	
371. PLACE OF SERVICE EMO		372. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
373. DIAGNOSIS POINTER		374. \$ CHARGES	
375. DAYS OR UNITS		376. ID. QUAL	
377. RENDERING PROVIDER ID. #		378. \$ CHARGES	
379. DATE(S) OF SERVICE From MM DD YY To MM DD YY		380. \$ CHARGES	
381. PLACE OF SERVICE EMO		382. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
383. DIAGNOSIS POINTER		384. \$ CHARGES	
385. DAYS OR UNITS		386. ID. QUAL	
387. RENDERING PROVIDER ID. #		388. \$ CHARGES	
389. DATE(S) OF SERVICE From MM DD YY To MM DD YY		390. \$ CHARGES	
391. PLACE OF SERVICE EMO		392. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
393. DIAGNOSIS POINTER		394. \$ CHARGES	
395. DAYS OR UNITS		396. ID. QUAL	
397. RENDERING PROVIDER ID. #		398. \$ CHARGES	
399. DATE(S) OF SERVICE From MM DD YY To MM DD YY		400. \$ CHARGES	
401. PLACE OF SERVICE EMO		402. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
403. DIAGNOSIS POINTER		404. \$ CHARGES	
405. DAYS OR UNITS		406. ID. QUAL	
407. RENDERING PROVIDER ID. #		408. \$ CHARGES	
409. DATE(S) OF SERVICE From MM DD YY To MM DD YY		410. \$ CHARGES	
411. PLACE OF SERVICE EMO		412. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
413. DIAGNOSIS POINTER		414. \$ CHARGES	
415. DAYS OR UNITS		416. ID. QUAL	
417. RENDERING PROVIDER ID. #		418. \$ CHARGES	
419. DATE(S) OF SERVICE From MM DD YY To MM DD YY		420. \$ CHARGES	
421. PLACE OF SERVICE EMO		422. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
423. DIAGNOSIS POINTER		424. \$ CHARGES	
425. DAYS OR UNITS		426. ID. QUAL	
427. RENDERING PROVIDER ID. #		428. \$ CHARGES	
429. DATE(S) OF SERVICE From MM DD YY To MM DD YY		430. \$ CHARGES	
431. PLACE OF SERVICE EMO		432. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
433. DIAGNOSIS POINTER		434. \$ CHARGES	
435. DAYS OR UNITS		436. ID. QUAL	
437. RENDERING PROVIDER ID. #		438. \$ CHARGES	
439. DATE(S) OF SERVICE From MM DD YY To MM DD YY		440. \$ CHARGES	
441. PLACE OF SERVICE EMO		442. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
443. DIAGNOSIS POINTER		444. \$ CHARGES	
445. DAYS OR UNITS		446. ID. QUAL	
447. RENDERING PROVIDER ID. #		448. \$ CHARGES	
449. DATE(S) OF SERVICE From MM DD YY To MM DD YY		450. \$ CHARGES	
451. PLACE OF SERVICE EMO		452. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
453. DIAGNOSIS POINTER		454. \$ CHARGES	
455. DAYS OR UNITS		456. ID. QUAL	
457. RENDERING PROVIDER ID. #		458. \$ CHARGES	
459. DATE(S) OF SERVICE From MM DD YY To MM DD YY		460. \$ CHARGES	
461. PLACE OF SERVICE EMO		462. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
463. DIAGNOSIS POINTER		464. \$ CHARGES	
465. DAYS OR UNITS		466. ID. QUAL	
467. RENDERING PROVIDER ID. #		468. \$ CHARGES	
469. DATE(S) OF SERVICE From MM DD YY To MM DD YY		470. \$ CHARGES	
471. PLACE OF SERVICE EMO		472. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
473. DIAGNOSIS POINTER		474. \$ CHARGES	
475. DAYS OR UNITS		476. ID. QUAL	
477. RENDERING PROVIDER ID. #		478. \$ CHARGES	
479. DATE(S) OF SERVICE From MM DD YY To MM DD YY		480. \$ CHARGES	
481. PLACE OF SERVICE EMO		482. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
483. DIAGNOSIS POINTER		484. \$ CHARGES	
485. DAYS OR UNITS		486. ID. QUAL	
487. RENDERING PROVIDER ID. #		488. \$ CHARGES	
489			

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input checked="" type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (ID)										1a. INSURED'S ID. NUMBER (For Program in Item 1) 22C457642																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 12/29/11 DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE																			
14. DATE OF CURRENT: MM DD YY 05 09 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE TERRY REZNICK D.O.										17a. NPI 1295874451										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 2. 847.1 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 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611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443. 1444. 1445. 1446. 1447. 1448. 1449. 1450. 1451. 1452. 1453. 1454. 1455. 1456. 1457. 1458. 1459. 1460. 1461. 1462. 1463. 1464. 1465. 1466. 1467. 1468. 1469. 1470. 1471. 1472. 1473. 1474. 1475. 1476. 1477. 1478. 1479. 1480. 1481. 1482. 1483. 1484. 1485. 1486. 1487. 1488. 1489. 1490. 1491. 1492. 1493. 1494. 1495. 1496. 1497. 1498. 1499. 1500. 1501. 1502. 1503. 									

KMRPPT0066575

STATE FARM INSURANCE
PO BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																											
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (ID)										1a. INSURED'S ID NUMBER (For Program in Item 1) 22-C449-799																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE SEX										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																	
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 07/18/11										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE																																																											
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JOHN J. HOBAN M.D.										17a. NPI 1144429762										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 8470 2. 847.1 3. 847.9																																																	
22. MEDICAID RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID #																																																	
105:02:11 05:02:11 11 97010 GP 123 60:00 1 SHAH NPI										25. FEDERAL TAX I.D. NUMBER SSN EIN 80-0503391 <input checked="" type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. BONT000 1045										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 375.00										29. AMOUNT PAID \$										30. BALANCE DUE \$ 375.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) SHAH SIGNED DATE 01/03/11										32. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.										33. BILLING PROVIDER INFO & PH. # (810)230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.																																																	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0065410

STATE FARM INSURANCE
PO BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE 07/25/11		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 03 08 11		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JOHN J. HOBAN M.D.		17a. NPI 1144429762	
19. RESERVED FOR LOCAL USE		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line) 1 8470		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
2. 1		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON FROM PER I. ID. QUAL. J. RENDERING PROVIDER ID. #		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO	
1 05 02 11 05 02 11 11 97035 GO 1 60.00 1		23. PRIOR AUTHORIZATION NUMBER	
2 05 02 11 05 02 11 11 97140 GO 1 60.00 1		RUTLEDGE	
3 05 02 11 05 02 11 11 97110 GO 1 75.00 1		NPI	
4 05 02 11 05 02 11 11 97535 GO 1 65.00 1		RUTLEDGE	
5 05 04 11 05 04 11 11 97010 GO 1 60.00 1		NPI	
6 05 04 11 05 04 11 11 97014 GO 1 55.00 1		RUTLEDGE	
25. FEDERAL TAX I.D. NUMBER SSN EIN 80-0503391 <input checked="" type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. BONTE000 1068	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this b3 and are made a part thereof.) RUTLEDGE SIGNED _____ DATE 11/11/10		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.		28. TOTAL CHARGE \$ 375.00 29. AMOUNT PAID \$ 375.00 30. BALANCE DUE \$ 375.00	
33. BILLING PROVIDER INFO & PH # (810) 230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.			

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

KMRPPT0065350

KMRPPT0050783

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22035F930	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [Blank]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [Blank]	
3. PATIENT'S BIRTH DATE MM DD YY [Blank]		5. INSURED'S ADDRESS (No., Street) [Blank]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [Blank]	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [Blank]	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) MI c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER [Blank]	
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED [Blank] SIGNATURE ON FILE DATE 10/31/11		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED [Blank] SIGNATURE ON FILE	
14. DATE OF CURRENT: MM DD YY 08 19 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE TERRY REZNICK D.O.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 2. 847.1 3. [Blank] 4. [Blank]		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. [Blank]	
23. PRIOR AUTHORIZATION NUMBER [Blank]		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PSYCH. FEES I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 09:01:11 09:01:11 11 97003 GO 12 300:00 1 NPI		RUTLEDGE	
2 09:01:11 09:01:11 11 97010 GO 12 60:00 1 NPI		RUTLEDGE	
3 09:01:11 09:01:11 11 97014 GO 12 55:00 1 NPI		RUTLEDGE	
4 09:01:11 09:01:11 11 97535 GO 12 65:00 1 NPI		RUTLEDGE	
5 09:02:11 09:02:11 11 97010 GO 12 60:00 1 NPI		RUTLEDGE	
6 09:02:11 09:02:11 11 97014 GO 12 55:00 1 NPI		RUTLEDGE	
25. FEDERAL TAX I.D. NUMBER SSN EIN 80-0503391 [Blank] [x]		26. PATIENT'S ACCOUNT NO. JOHWI000 1344	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 595.00	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 595.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) RUTLEDGE 11/11/10 SIGNED [Blank] DATE		32. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b. [Blank]	
33. BILLING PROVIDER INFO & PH. # (810)230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b. [Blank]			

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0838-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0050883

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22035F930	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) MI c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY SEX F <input checked="" type="checkbox"/> M <input type="checkbox"/>	
13. EMPLOYER'S NAME OR SCHOOL NAME		14. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE	
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17. SIGNATURE ON FILE SIGNED _____ DATE 10/31/11		18. SIGNATURE ON FILE SIGNED _____	
19. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 08 19 11 INJURY		20. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE TERRY REZNICK D.O.		22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
23. RESERVED FOR LOCAL USE		24. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by line) 1. 847.9		26. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.	
27. PRIOR AUTHORIZATION NUMBER		28. DATE(S) OF SERVICE From MM DD YY To MM DD YY	
29. PLACE OF SERVICE EMG		30. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
31. DIAGNOSIS POINTER		32. \$ CHARGES	
33. DAYS OR UNITS		34. ID. QUAL	
35. RENDERING PROVIDER ID. #		36. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SONI 09/19/11 SIGNED _____ DATE	
37. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.		38. BILLING PROVIDER INFO & PH. # (810)230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.	
39. FEDERAL TAX I.D. NUMBER 80-0503391		40. PATIENT'S ACCOUNT NO. JOHWI000 1343	
41. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		42. TOTAL CHARGE \$ 360.00	
43. AMOUNT PAID \$		44. BALANCE DUE \$ 360.00	

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0050785

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE		MEDICAID		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S ID. NUMBER (For Program in Item 1)															
												<input checked="" type="checkbox"/>		22035F930															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE				SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)													
												Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																	
8. PATIENT STATUS																													
Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																													
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER													
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH													
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>													
b. OTHER INSURED'S DATE OF BIRTH												b. AUTO ACCIDENT?				b. EMPLOYER'S NAME OR SCHOOL NAME													
MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>												<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MI																	
c. EMPLOYER'S NAME OR SCHOOL NAME												c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME													
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				STATE FARM INSURANCE													
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?													
																<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																	
SIGNED SIGNATURE ON FILE DATE 10/31/11												SIGNED SIGNATURE ON FILE																	
14. DATE OF CURRENT: MM DD YY												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION													
08 19 11																FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
TERRY REZNICK D.O.												17b. NPI 1295874451				FROM MM DD YY TO MM DD YY													
19. RESERVED FOR LOCAL USE																20. OUTSIDE LAB? \$ CHARGES													
																<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line)																22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.													
1. 8470																													
2. 847.1																23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE												B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EP807 PENDING PCH		I. ID QUAL		J. RENDERING PROVIDER ID. #	
MM DD YY MM DD YY												MM DD YY				CPT/HCPCS MODIFIER													
1 09:02:11 09:02:11 11												11				97035 GO		12		60.00		1				NPI		RUTLEDGE	
2 09:02:11 09:02:11 11												11				97124 GO		12		60.00		1				NPI		RUTLEDGE	
3 09:08:11 09:08:11 11												11				97010 GO		12		60.00		1				NPI		RUTLEDGE	
4 09:08:11 09:08:11 11												11				97014 GO		12		55.00		1				NPI		RUTLEDGE	
5 09:08:11 09:08:11 11												11				97035 GO		12		60.00		1				NPI		RUTLEDGE	
6 09:08:11 09:08:11 11												11				97124 GO		12		60.00		1				NPI		RUTLEDGE	
25. FEDERAL TAX ID. NUMBER												SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE							
80-0503391												<input checked="" type="checkbox"/>		JOHWI000 1344		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 355.00		\$		\$ 355.00							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & P.H. #															
RUTLEDGE												NEW ERA PT SERVICES		(810)230-0444															
11/11/10												G 4007 W. COURT ST. SUITE G2																	
SIGNED DATE												FLINT, MI 48532																	
												a. 1336469139																	
												b. 1336469139																	

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WCMS-1500CS

KMRPPT0050885